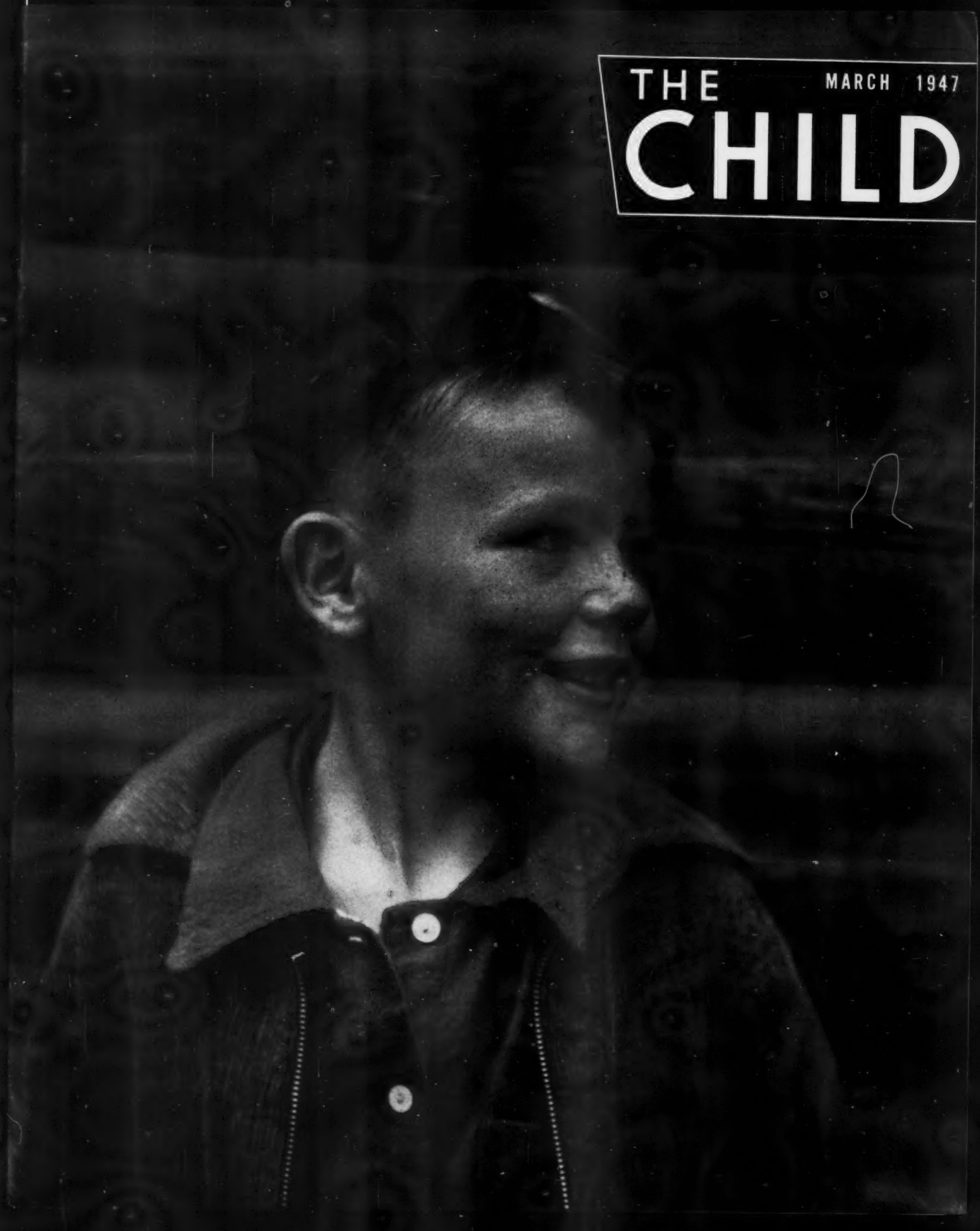


THE CHILD

MARCH 1947

WHY NOT AN OUNCE OF PREVENTION?

Plenty of action at a club. Not a cure for delinquency, but one kind of preventive medicine.

CLARENCE W. MEADOWS

Governor of West Virginia

QUITE FRANKLY, I am not an authority on juvenile delinquency. My thoughts on the subject arise solely from experience gained as a legislator, a prosecuting attorney, an attorney general, a judge, and a Governor. I am unwilling to concede that one may become an authority by the mere study of certain accepted courses dealing with human relations and our social problems. Most certainly all of us who are so vitally interested in this subject keenly feel our individual inadequacy to find the correct solution. Hence the great and impelling necessity to pool all our experience, all our technical training, in order that we may find the right answers for intelligent and effective action at this propitious time.

So highly individualistic is the problem that the great need for more experienced, trained personnel becomes at once apparent, as does the equal need for institutions fully equipped to meet the challenge.

Young lives can never be reoriented in our twentieth century by the medieval method of arrest, conviction, and confinement. Too often, the juvenile offender or delinquent receives the same care as the hardened criminal, and this, instead of salvaging a young life, immediately and too often transforms that youngster into the very kind of citizen we so piously profess to be trying to keep him from being.

Condensed from an address before the National Conference on Prevention and Control of Juvenile Delinquency, Washington, November 20, 1946.

I have seen it, and I have had to deal with it on this plane, and as long as our cities, counties, States, and Federal Government fail to recognize the need for a higher degree of care and guidance for the youngsters of our land who have in some manner transgressed, we can expect no better results in the future than those we have achieved in the past.

Young boys or young girls full of life, unmindful—even as you and I were perhaps somewhat unmindful at one time—of the consequences of their acts, who find themselves suddenly deprived of the freedom they have known . . . and who are forced to pay the penalty for their transgression by merely staring at walls for days without end, can hardly be expected to fall in love with a society which has placed them there. For most of them, there must be another and a much better way.

The cure of any disease is, of course, much to be desired, but of far greater benefit to humanity is the prevention of the disease. And so it is with juvenile delinquency. Important as it is to salvage a youngster who has strayed, it is of much greater importance to society as a whole, and to the future of this Nation, to develop programs or plans which can, in some manner and by some means, effect the prevention of juvenile delinquency. In my honest judgment, it is here that we in government have too long been too neglectful. Now is the time to begin the assumption of our real responsibility.

If juvenile delinquency is to be finally placed among those social problems which are to be considered as solved, the point at which we must begin—and begin in earnest—is that point where the preventive is indicated.

In my State, as well as in each of yours, and in the Federal Government, juvenile delinquency has been widely discussed. Yes, we recognize this to be a problem. We talk about it. We deplore it. But we end up by doing very little about it. In truth, what has been our greatest effort? I believe the sum total amounts to something like this: We have our juvenile courts and juvenile officers. We have our detention homes, our industrial schools, and places for confinement and training, but beyond that we have devoted little effort except the effort of discussion. We appropriate money. We provide machinery—inadequate as it all is—to cure, but what money have we appropriated—what are we doing governmentally on the preventive side? Very little, I am afraid.

Never before has this problem assumed the proportions that it possesses today. The war has disrupted the life of every citizen and every home, and the strains and stresses of our times have torn the people of our Nation, as well as the people of the world, loose from our strong and stable moorings. So, until the passing of time brings to us a more placid existence, when we shall give higher value to moral and social responsibility, the tide of juvenile offenses will continue to rise unless we meet the problem in a way different from that in which we have been meeting it in the past.

I propose that our governmental units—municipal, State, and Federal—while doing all things possible to cure juvenile delinquency, immediately recognize that our real responsibility begins with prevention rather than with cure. To my mind, the devotion of specialized facilities, highly trained personnel, and liberal appropriations for prevention will pay much higher dividends in good citizenship than anything we can do in the curative field.

Why not start at the beginning? Let us get to the cause of the trouble, rather than begin after the damage has been done.

. . . . . .

We in the States and those in the Federal Government have too long dwelt solely upon, and expended our major efforts in, taking care of those who are ill mentally and morally—and that care has not been too good—instead of devoting our resources and our great wealth to the prevention of the very problem we seek to solve. It would be calling upon your imagination, I am sure—because the living examples of such are so few and far between—to envision what might really be done for the youth of our land, for our future citizens, if we would only devote a small portion of our resources to the carrying out of a program designed to keep juveniles from being delinquent—to give juveniles who have had little opportunity to see other than the seamy side of life, the privilege of enjoying things which make better men and women—the opportunity of lifting themselves up and enjoying life as it should be lived by clean, wholesome youngsters.

Detention in jail is a poor way to deal with delinquent youth.

Some Children's Bureau publications related to prevention and control of juvenile delinquency

BUILDING THE FUTURE FOR CHILDREN AND YOUTH; next steps proposed by the National Commission on Children in Wartime. Pub. 310. 1945. 59 pp.

CHILDREN IN THE COMMUNITY; the St. Paul experiment in child welfare. Pub. 317. 1946. 182 pp.

CHILDREN IN JAIL. Reprinted from "The Child," April 1943. 5 pp.

COMMUNITY EXPERIMENT IN THE MEASUREMENT OF JUVENILE DELINQUENCY. Reproduced from National Probation Yearbook, 1946. 27 pp.

CONTROLLING JUVENILE DELINQUENCY; a community program. Pub. 301. 1943. 27 pp.

COORDINATING MENTAL-HYGIENE WORK FOR CHILDREN. Reprinted from "The Child," June 1945. 4 pp.

GOALS FOR CHILDREN AND YOUTH IN THE TRANSITION FROM WAR TO PEACE. Adopted by the National Commission on Children in Wartime. Pub. 306. 1944. 12 pp.

GUIDING THE ADOLESCENT. Pub. 225. Revised 1946. 83 pp.

HANDBOOK FOR RECREATION LEADERS. Pub. 231. 1936. 121 pp.

JUVENILE-COURT STANDARDS. Pub. 121. Revised 1937. 10 pp.

JUVENILE-COURT STATISTICS, 1944 and 1945. 12 pp.

MENTAL HYGIENE FOR CHILDREN AND YOUTH; a joint committee statement submitted for consideration to the Committee on Plans for Children and Youth of the National Commission on Children in Wartime. 1945. 15 pp. Mimeographed.

OUR CONCERN—EVERY CHILD; State and community planning for wartime and postwar security of children. Pub. 303. 1944. 84 pp.

STATE AND COMMUNITY PLANNING FOR CHILDREN AND YOUTH; proposals of the National Commission on Children in Wartime. Pub. 312. 1945. 21 pp.

UNDERSTANDING JUVENILE DELINQUENCY. Pub. 300. 1943. 52 pp.

WHITE HOUSE CONFERENCE ON CHILDREN IN A DEMOCRACY—Final Report. Pub. 272. 392 pp.

PREVENT DELINQUENCY THROUGH SERVICES FOR *ALL* CHILDREN

TOM C. CLARK

Attorney General of the United States

SINCE THE CAUSES of juvenile delinquency are found in all aspects of our social and economic life, the problem must not be approached on a narrow basis.

Furthermore, these causes have been accentuated by wartime conditions, and by the changes and stresses which aggravate the problem still more as the Nation returns to the days of peace.

We must not only meet the present emergency; we must lay long-range plans for the future.

We must always remember that the same kind of coordinated effort is required for the prevention and control of juvenile delinquency in normal times as is needed in times of special stress such as we experienced during the war and are now experiencing in the days of reconversion.

. . . each and every community must marshall all its social forces in the war against delinquency. The extent to which a juvenile receives a socialized type of treatment should not depend upon whether he lives in the North, South, East or West, nor upon whether he is a State or Federal offender.

All agencies and people concerned in the prevention or control of juvenile delinquency should pull together, and gird themselves for the common task. . . .

. . . . .

It is of primary importance that we emphasize the strengthening of services that are essential to the well-being of *all* children.

If every community in America strengthened and united its resources for *all* of its children, it would save *many* of them from taking the first stumbling steps toward delinquency.

. . . . .

Those recently returned from the battlefields of freedom learned that no artificial barriers—racial, religious, or economic—separated men on the fighting front.

Yet some people now act as if good will, understanding, and friendship among men belong only to wartime.

Some individuals, some groups, would turn the hand of one man against another because of difference in race, color, or creed.

. . . . .

Incidentally, 27 percent of our present population are foreign-born, or the children of foreign-born parents or parent.

Indeed, all races and nationalities make up America and contribute to its life.

During the recent war about 109,000 soldiers in American uniform were naturalized, approximately 14,000 of them while on duty overseas. These American soldiers were of 122 different nationalities.

. . . . .

The gap that normally exists between generations is often widened by differences in the customs, traditions, and attitudes of the Old and New Worlds, making the children—especially the native-born children of foreign-born parents—more vulnerable to delinquency.

. . . . .

Delay in community action to mobilize resources to lead children into rich and purposeful living until some are already in trouble is more costly, more difficult, and often too late.

. . . . .

The problem of how best to deal with the juvenile delinquent as an individual to be put back on the road which leads to a happy and useful life, a credit both to society and himself, is common to all communities. It does not differ from jurisdiction to jurisdiction.

Excerpts from an address before the National Conference on Prevention and Control of Juvenile Delinquency, Washington, November 20, 1946.

All children are entitled to happy, wholesome home life. The right kind of home life is vital to the welfare of the child. It is vital also to the welfare of the Nation.

But the home is not complete within itself. It must be fortified and supplemented by the church, the school, and other forces in the community.

After each great crisis in our national life there always seems to be a moral and spiritual letdown. I am happy, therefore, to note that reemphasis of moral and spiritual values is to be given attention.

Society cannot afford to contribute to the delinquency of its children by allowing spiritual guidance and social education to lag behind economic and scientific development.

The church has primary responsibility for spiritual guidance. It can help children distinguish between fundamental values in human conduct and transient ideas as to acceptable and unacceptable behavior. In essence, the church can help to guide youth in the formation of a scale of values in keeping with the principles of democratic living.

. . . . .

The school is strategically placed to reach practically all children. Also it reaches them at an early and impressionable period of life. The school that sees the child's school experience as a part of life itself, as well as preparation for life, can develop healthful habits—mental and physical, proper attitudes and interests and a sense of civic responsibility.

The school is in a position to recognize attitudes and behavior that may be the forerunners of delinquency. An all-round good school helps to prevent delinquency.

Everyone has need for fun, relaxation and release, and self-expression. Recreation can play an important role in the conservation of youth as it meets the needs of millions of our young people.

As services become more nearly adequate for the millions of our youth, offenders and delinquents will become fewer.

Passing from the general requirement of meeting the needs of all children, we know that specialized services are necessary to meet the special needs of certain children.

For example, some children require special protection of the community. They are the physically and mentally handicapped children, the boys and girls in employment, the children of working mothers, and the children who live in congested areas, or whose families are in economic need.

In addition, some community conditions are destructive to the welfare of children. The elimination, or control, of such harmful or potentially harmful influences that lead children into delinquency is a public responsibility.

. . . . .

The delinquent child or youth needs the basic services and resources that are essential for all children. He needs the protections that are necessary for the child in danger of becoming delinquent. He needs skillful handling of his own particular problems.

He needs help from the home, the school, the church, the youth-serving organizations, the social agencies, the law-enforcement bodies, and all the other forces in the community that can play any part in his training, readjusting, and re-creating.

. . . . .

This multiple approach to the problem of juvenile delinquency, its prevention and control, involves a community of social forces and a concentrated and coordinated effort on the part of all in building a well-rounded and evenly developed program.

. . . . .

We can meet and mobilize public opinion concerning the problem with which we are confronted—we can make specific recommendations for action; can carry out some of these recommendations. But the essential responsibility must rest with the local communities. It is for them to utilize the reports and the results of this conference. It is for them to take these reports and to translate them into coordinated community effort.

TOOLS FOR ACTION TO PREVENT AND CONTROL DELINQUENCY

AT THE CLOSE of the National Conference on Prevention and Control of Juvenile Delinquency, held November 20–22, 1946, at Washington, 15 discussion panels presented their final reports, on various phases of the problem, to the conference in plenary session. Summaries of these reports are now available in a bulletin, "Recommendations for Action," published recently by the Department of Justice. (Washington, 1947. 136 pp.) The full reports will be made available as soon as they can be printed.

Each of the panel reports, says the bulletin, is a "tool for action," primarily at the community level. Each recommendation has been specifically allocated to individuals or groups, who, in the opinion of the conference, have the primary responsibility in the community for initiating the particular action and carrying it through.

Planning for prevention of delinquency, says the report on community coordination, should be an integral part of the community's programs of health, recreation, housing, and schools; a part of its religious, economic and business life; as well as of its programs for courts and police, and its protective services for children with definite behavior problems.

The report on institutional treatment of delinquent juveniles lists the phases of treatment that are designed to make such institutions places for the reeducation and retraining of the individual children committed to their care.

The "Standard Juvenile Court Act," drafted by the National Probation Association and revised in 1943, is endorsed by the report of the panel on juvenile-court laws, administration, and detention facilities. The panel also suggests some amendments to the standard act.

Well-qualified personnel needed

The section of this panel's report that is devoted to administration of juvenile courts calls attention to the need for well-qualified personnel and for procedures and facilities suitable for dealing with the problems of children.

States and communities are in great need of field-consultant service concerning detention, says the section on detention facilities, and this service might well be provided by national agencies.

The report on the role of the police in juvenile delinquency sets forth the

Here it is Saturday, and no place to go. Boys as bored as these may seek the kind of excitement that leads to trouble.

views of the majority of the panel, but says that minority opinions were voiced as to certain parts of the report and as to certain of the recommendations. The report develops the point of view that primary consideration on the part of all agencies dealing with the control and prevention of juvenile delinquency is the protection of society, with the needs and privileges of the individual being given secondary, but very important consideration.

Recreation is no cure-all for juvenile delinquency, says the report on recreation for youth. But it may make an important contribution to the social treatment of delinquent juveniles, and it is one of the effective instruments for the prevention of delinquency. Recreation serves best as a preventive force when opportunities for wholesome recreation are provided for all youth everywhere, according to the report.

Individual citizen responsible

"This means YOU." Thus the report on housing and community development addresses the individual citizen in making clear that the responsibility for bringing about a better environment for American youth belongs to every one of us. The report also recommends specific action by private builders, banks, labor leaders, religious leaders, legislative bodies, mayors, health departments, housing authorities, and other agencies.

The report on youth participation itself is an example of youth participation. Four young persons (the oldest 24 and the youngest 17), assisted in preparing the report, and there was no thought of considering them as a group apart from the older people. Their ideas and suggestions were accepted or modified after discussion in exactly the same way as those of their elders.

In directing its attention to the potentialities and responsibilities of all citizens in accomplishing the objectives of the conference, the report on citizen participation addresses its recommendations not only to individual citizens but also to youth-serving and other community agencies and to community-planning groups.

The bases for socialized behavior are laid in childhood, says the report on mental-health and child-guidance clinics. All who deal with children, the report goes on to say, have the obligation to acquaint themselves with the fundamental emotional and mental needs of childhood and to realize how the frustrations or satisfactions of these needs are reflected immediately or later in behavior. Knowledge of the part that the fundamental needs play in the development of the young individual really means acquaintance with mental-hygiene principles. Understanding and proper application of these principles, the panel believes, will go far in reducing juvenile delinquency.

How social services can help delinquent children and their parents is suggested in the report on case-work and group-work services. The contribution that case-work and group-work programs can make to the solution of the problem of juvenile delinquency is of necessity closely related to the broad social programs that are designed to assure the economic, social, and physical well-being of each person in the Nation. Case workers and group workers share with other citizens the responsibility to work for the establishment of such programs.

The report on church responsibilities opens with a positive assertion of the importance of religion in the prevention and control of juvenile delinquency. It states that religion (and that means church and synagogue) is not merely an adjunct or ally of other social forces combating delinquency, but is fundamental to the best that they have to offer. The recommendations urge that priests, ministers, and rabbis cooperate closely with the police, probation officers, judges, social workers, school officials, mental-hygiene clinics, and other agencies dealing with children who have behavior problems. They urge also that all religious groups encourage their congregations to respect people with different cultural and religious backgrounds.

Assisted by all other forces of the community, the school can and should attack the problems of juvenile delinquency, according to the report on school and teacher responsibilities. The school, because of its constant and intimate contact with all the children, occupies a strategic position in attacking this problem, the panel says. Although the larger part of the attention of the school should be directed toward developing a complete school program that will make the pupils less likely to form undesirable patterns of behavior, the report goes on, the school must also accept responsibility for dealing with such behavior when it occurs.

To help families

Specific suggestions to parents are made by the panel report on home responsibility to help them understand the tensions that cause antisocial behavior in their children. The recommendations place emphasis on the personal adjustment and positive attitudes that help make a "good" home.

Delinquency statistics, according to the report on that subject, may be classified into three groups: (1) Data on the numbers and characteristics of children dealt with as delinquent; (2) data on the character of and circumstances surrounding delinquent acts; (3) data on socioeconomic and psychological factors involved in delinquency.

A realistic approach to the problems of juvenile delinquency in rural areas needs to take cognizance of the distinctive patterns of rural life, says the report on rural aspects of juvenile delinquency. Most obvious of these is that rural people live less close together than urban people; they rely more on personal contacts; the maturing children have a more responsible part in making the family living; there is less formal organization and more informal activity; and behavior is determined more by local custom and less by law than in urban communities. There is need for capitalizing on the conditions in rural life that tend to hold juvenile delinquency to a minimum, and to develop programs for dealing constructively with such delinquency as does occur. Though it is clear that juvenile delinquency in rural areas, as elsewhere, can be effectively prevented and controlled only by the community itself, local leaders will want to profit from the experiences of other communities and from the assistance they can obtain from Federal and State agencies.

An additional panel, on press, radio, and motion pictures, also met during the conference, and plans to conduct a postconference study of the other reports and then submit its report.

WARTIME INFANT AND MATERNAL MORTALITY RATES SHOW CONTINUED IMPROVEMENT

a summary for 1943 and 1944

DESPITE wartime conditions, and the withdrawal of a very large number of physicians from civilian practice to serve in the armed forces, a steady improvement took place throughout the war in the Nation's maternal and infant mortality rates.

From 45.3 per 1,000 live births in 1941, the death rate among infants dropped year by year until, in 1945, it reached the lowest level, 38.3, ever achieved since mortality records were first kept. From 31.7 per 10,000 live births in 1941, the death rate among mothers during childbearing, likewise, dropped to its lowest—20.7—in 1945. Provisional figures for the first 9 months of 1946 indicate that the trend toward lower infant and maternal mortality is continuing.

During the latter half of this time—beginning with April 1943—the Emergency Maternity and Infant Care program was in operation. Under this program medical, nursing, and hospital services for maternity care were made available to more than 962,000 servicemen's wives through the end of 1945 and, during the same period, to almost 132,000 infants during their first year of life. The effect of this program on maternity and infant mortality rates cannot be definitely stated.

This steady reduction in death rates for mothers and infants occurred against a fluctuating birth rate. Climbing from 18.9 births per 1,000 population in 1941, the birth rate reached its wartime peak in 1943 with 21.5. In 1944 it dropped to 20.2. In 1945 it dropped again to 19.6. (Preliminary estimates made by the Bureau of the Census predict a sizable upswing in 1946, when it is expected the number of births will exceed any in the history of the country.)

The following analysis of these vital statistics for 1943 and 1944 is a summary of a more complete presentation by Dr. George Wolff, which will appear as a separate monograph under the title, "Maternal and Infant Mortality in 1944." Readers interested in receiving this publication are invited to address requests for a free copy to the U. S. Children's Bureau, Washington 25.

Data on the years 1933 to 1943 are given in "Ten Years of Progress in Reducing Maternal and Infant Mortality," by Dr. Marjorie Gooch, a reprint from *The Child*, November 1945, copies of which are also available.

Births

1944 marked the turning point in the wartime increase that took place in births. The number registered for that year, 2,794,800, was 5 percent lower than the 2,934,860 registered in 1943, the year of the greatest number of live births during the war. Of the 1944 total, 1,435,301 were boys; 1,359,499 were girls. That is, for every 100 female infants, there were 106 male infants.

Based on the estimated midyear population, including armed forces overseas, the birth rate per 1,000 population was 20.2 in 1944, compared with 21.5 in 1943.

Complete registration of births has not yet been achieved in our country. Although, since 1933, the entire continental United States has been included in the birth-registration area, here and there births still take place which go unrecorded. From a test made in 1939–40 by the Bureau of the Census, some 200,000 births occurring each year appear to be unregistered. Registration of white births is estimated as 94 percent complete; of nonwhite births, 82 percent complete.

Birth rates for the United States from 1933 to 1944:

Year	Rate	Year	Rate
1933	16.6	1939	17.3
1934	17.2	1940	17.9
1935	16.9	1941	18.9
1936	16.7	1942	20.9
1937	17.1	1943	21.5
1938	17.6	1944	20.2

The State with the highest birth rate in 1944 was New Mexico, where 32.1 births per 1,000 population were registered. South Carolina was next, with 29.0; and Mississippi third, with 28.9. New York had the lowest rate (18.6) for any State, and was followed by New Jersey (18.8) and Illinois (18.9). In general, Southern States and some of the Mountain States (New Mexico, Utah, Idaho) have rates above the United States average, while in the more industrialized States of the Northeast the rates usually fall below the national average.

Of the 2,794,800 registered live births in 1944, 2,454,700—or 87.8 percent—were white; 324,183—or 11.6 percent were Negro; 15,917—or less than 1 percent—were of other nonwhite races. Distribution in 1943 was very similar.

The birth rate for the nonwhite population, as in preceding years, was higher than for the white population. In 1944 the nonwhite rate was 23.7 per 1,000 population, against the white, 19.8. Breaking down the figure for the nonwhite group brings out some interesting racial comparisons. The lowest birth rate for 1944 occurred among the Chinese, 16.3 per 1,000 population. For persons of Japanese origin, the rate was 23.0. For Negroes, who make up all but 1 percent of the whole nonwhite group, the rate was 23.7. Indians had the highest rate, with 28.5 registered births per 1,000 Indian population. This high birth rate among Indians, however, must be matched against their death rate, which continues higher than for the Negro or white population.

Maternal Mortality

1944 stands out significantly as the year with the lowest maternal mortality rate recorded for the United States

from the beginning of birth registration in 1915 up to that time. The rate was 22.8 per 10,000 live births, as compared with 24.5 in 1943, and 25.9 in 1942.

In actual numbers 6,369 deaths from puerperal causes occurred in 1944. This was 11.5 percent fewer than the deaths in 1943, and 12.4 percent fewer than in 1942.

A comparison of the rates in 1942 and 1944, when the total number of live births was almost the same, shows that nearly 900 more mothers would have died in 1944 if the 1942 rate had prevailed.

By States—Twenty-eight States and the District of Columbia in 1944 had rates better than the 22.8 average for the country; 20 had poorer rates. Records of the various States point up the still further gains that could be made if all States had records as favorable as the most advanced States.

Wyoming took first place as the State with the lowest maternal mortality rate. With 5,635 births, five mothers lost their lives. Wyoming's rate, therefore, was 8.9 per 10,000 live births. If all States had had the same low rate, the loss of life for the Nation as a whole would have been half as great as it actually was. However, the low rate in Wyoming this year might be partly due to chance.

Wyoming was followed by Utah with 13.6, and Minnesota with 13.7. The States with the highest maternal mortality rates were New Mexico (39.8), Mississippi (38.5), and South Carolina (37.5).

By race—Risks of childbearing, the 1944 record shows, continue to bear unevenly on white and nonwhite mothers. For the whole country, the death rate for white mothers was 18.9 per 10,000 live births; for nonwhite mothers, it was 50.6—almost three times as high. It is not surprising, then, to find the States with sizable nonwhite populations showing the poorest record, and these figures point directly to groups most urgently in need of better care. While there was a decrease of 10 percent between 1943 and 1944 in mortality rates for white mothers, the decrease for nonwhite mothers was less than 1 percent. As one authority recently said: "Obstetric care has undergone an evolution in this generation, but the Negro has not participated fully in the benefits of modern obstetrics. It is not possible to have two systems of maternal welfare; there must be one all-inclusive health program." [1]

By age—If maternal mortality can serve as a criterion, the age most favorable for having children is 20 through 24. Both in 1943 and 1944, the mortality rates for this age group were the lowest. The rate in 1943 was 15.8; in 1944, 14.2. The youngest mothers, 10 through 14, who have hardly reached physical maturity, have a very high death rate from puerperal causes—99.0 in 1943, 42.1 in 1944. Older mothers also have a rate considerably worse than average. For mothers 35 through 39 the rates were 51.0 in 1943 and 45.4 in 1944; for those 40 and over they were 76.6 in 1943 and 69.8 in 1944. It is encouraging that the decline in maternal mortality rates applies to all age groups.

By cause—Of the 6,369 maternal deaths in 1944, 2,276 or 36 percent were caused by puerperal infection (septicemia, phlebitis, thrombophlebitis, pyelitis, etc.); 1,607, or 25 percent, by all kinds of puerperal toxemia; and 1,897, or 30 percent, by hemorrhages of pregnancy and childbirth, including trauma and shock.

These three main causes taken together accounted for 91 percent of all maternal deaths in both 1944 and 1943. In general, the rate of decrease in each of the three causes tends, over a period of years, to be about the same.[2]

An analysis of maternal deaths according to termination of gestation brings other facts to light. Two-thirds of deaths following abortion (gestation less than 28 weeks) both in 1943 and 1944 were caused by infection. A majority of the deaths occurring before delivery were caused by toxemia. The principal causes of death in 1944 during or after delivery were: (1) Hemorrhage, trauma, and shock; (2) infection; and (3) toxemia. As might be

[1] Williams, Philip F.: Maternal Welfare and the Negro. Journal of American Medical Association, 132: 611–614 (Nov. 16, 1946)

[2] Gooch, Marjorie: Ten Years of Progress in Reducing Maternal and Infant Mortality. *The Child*, 10: 77–83 (November 1945).

MATERNAL MORTALITY: UNITED STATES AND EACH STATE, 1944 AND 1943 [1]

Area	1944		1943	
	Number of maternal deaths	Rate (deaths) per 10,000 live births)	Number of maternal deaths	Rate (deaths per 10,000 live births)
United States	6,369	22.8	7,197	24.5
Alabama	278	37.4	260	33.5
Arizona	42	29.5	38	26.6
Arkansas	114	27.6	168	39.4
California	304	17.0	357	20.5
Colorado	59	24.7	63	25.9
Connecticut	52	15.2	63	16.2
Delaware	9	15.0	15	24.1
District of Columbia	33	20.9	35	21.8
Florida	161	33.3	173	37.0
Georgia	279	36.5	307	39.2
Idaho	30	24.5	29	23.4
Illinois	254	17.9	320	20.5
Indiana	141	19.8	149	20.0
Iowa	83	17.8	80	16.8
Kansas	64	18.3	77	21.4
Kentucky	159	24.8	163	24.9
Louisiana	207	33.9	159	32.1
Maine	40	22.5	42	22.2
Maryland	82	18.7	85	17.9
Massachusetts	140	17.9	173	20.1
Michigan	193	16.8	226	18.0
Minnesota	77	13.7	84	14.4
Mississippi	219	38.5	236	39.4
Missouri	152	22.4	183	25.3

Area	1944		1942	
	Number of maternal deaths	Rate (deaths) per 10,000 live births)	Number of maternal deaths	Rate (deaths per 10,000 live births)
Montana	16	14.6	20	17.5
Nebraska	43	17.3	42	16.8
Nevada	7	23.1	6	19.8
New Hampshire	24	28.1	25	26.7
New Jersey	120	15.7	161	19.4
New Mexico	62	39.8	71	46.7
New York	425	18.5	521	21.0
North Carolina	266	29.4	306	32.4
North Dakota	24	17.7	39	29.1
Ohio	257	19.2	324	22.5
Oklahoma	111	23.8	122	25.1
Oregon	43	17.8	38	14.9
Pennsylvania	454	25.5	493	24.7
Rhode Island	25	18.2	33	22.5
South Carolina	193	37.5	240	44.3
South Dakota	23	18.0	20	15.6
Tennessee	191	28.0	204	29.1
Texas	422	25.4	420	25.5
Utah	22	13.6	27	15.7
Vermont	13	19.1	16	21.9
Virginia	183	26.5	210	29.1
Washington	70	15.7	72	16.2
West Virginia	89	21.5	126	29.1
Wisconsin	109	17.7	127	19.7
Wyoming	5	8.9	9	15.5

[1] Tabulations are by place of residence of deceased.

expected, the great majority (four-fifths) of the deaths during ectopic gestation were due, in both years, to hemorrhages.

Infant Mortality

Just as with maternal mortality, 1944 marked the lowest point in infant mortality rates between 1915 and that year. For 1944 the rate as usually computed was 39.8; for 1943, 40.4; for 1942, 40.4. (Adjusted for the changing number of births, these rates were: 39.4 in 1944; 40.7 in 1943; and 41.2 in 1942.) In actual numbers 111,127 infants died in 1944, 118,484 in 1943, and 113,492 in 1942.

Risk of death, it is well known, is greater for male than for female infants, and the record for 1944 further confirms this. Of the 111,127 infants who died, 63,264 were male, and 47,863 were female. Even when infant deaths are measured against the number of births in each sex, the rate is distinctly higher among boys than girls.

By States.—National averages obscure the advances some States have made in reducing their infant mortality rates. For white and nonwhite groups combined, 25 States in 1944 did better than the country as a whole; 23 States and the District of Columbia did less well.

Oregon had the best record, with 30.5 infant deaths per 1,000 live births. Connecticut came next, with 30.7; and Minnesota third, with 31.3. At the bottom of the list stood New Mexico (89.1); Arizona (68.8); and South Carolina (54.9).

States with predominantly white population tend to have lower rates. But even in States with large nonwhite population the white rate is frequently better than the average for the country. This is true, for instance, in the District of Columbia and in Maryland, where the white rates are below the national average while the nonwhite are well above it.

By race—Differences in mortality rates between white and nonwhite infants point up in still another way possible gains to be made in the future. Mortality among white infants in 1944 averaged for the country 36.9 for every 1,000 live births. Among nonwhite infants, it was 60.3.

While greater gains were made between 1943 and 1944 in the reduction of maternal mortality rates among white mothers than among nonwhite, the reduction in the infant mortality rate was 1.6 percent for white infants and double that (3.5 percent) for nonwhite infants.

Causes of death—In 1944, as in 1943, the five leading causes of infant mortality were: (1) Premature birth; (2) pneumonia and influenza; (3) congenital malformations; (4) injury at birth; (5) diarrhea, enteritis, etc. Nearly three-quarters of all infant deaths in 1944 were due to these. Close to one-third were deaths of premature infants.

Acute infectious diseases of childhood, such as measles, scarlet fever, whooping cough, and diphtheria, and the more chronic infections, such as dysentery, tuberculosis, and syphilis, continue to shrink in importance.

Significant differences between white and nonwhite infant mortality figures show up here. Although the absolute numbers are small when compared with the leading causes of death, death from syphilis is 13 times and from tuberculosis 5 times as frequent among nonwhite as among white infants. Death from congenital malformations is one of the few groups in which nonwhites show a definitely lower rate (about half in 1944 and 1943) than do whites.

By age at death—Infant mortality continues highest on the first day of life, declining gradually from day to day, from week to week, and from month to month. Of the 111,127 infant deaths in 1944, 29 percent occurred on the first day (same as in 1943); 33 percent after the first day but before the end of the first month (32 percent in 1943). The remainder occurred during the following 11 months of life.

Neonatal mortality (under 1 month) has not decreased to the same degree as the mortality rate in succeeding months, with the result that the proportion of neonatal deaths to all infant deaths has been increasing during recent years. If infant mortality is to be decreased, there must be more and more concentration on the neonatal period.

Another area needing increased attention is the problem of stillbirths. For

(*Continued on page 158*)

INFANT MORTALITY: UNITED STATES AND EACH STATE, 1944 AND 1943 [1]

Area	1944		1943	
	Number of infant deaths [2]	Rate (deaths per 1,000 live births)	Number of infant deaths [2]	Rate (deaths per 1,000 live births)
United States	111,127	39.8	118,484	40.4
Alabama	3,389	45.5	3,477	44.8
Arizona	979	68.8	1,097	76.7
Arkansas	1,433	34.7	1,594	37.4
California	6,177	34.5	5,999	34.4
Colorado	1,183	49.4	1,228	50.4
Connecticut	1,054	30.7	1,162	29.8
Delaware	292	48.7	291	46.7
District of Columbia	706	44.8	765	47.6
Florida	2,202	45.5	2,181	46.7
Georgia	3,407	44.5	3,656	46.6
Idaho	416	34.0	396	32.0
Illinois	4,602	32.4	5,184	33.3
Indiana	2,462	34.5	2,960	39.6
Iowa	1,540	33.1	1,618	34.0
Kansas	1,163	33.3	1,212	33.6
Kentucky	2,997	46.7	3,280	50.9
Louisiana	2,824	46.3	2,773	44.7
Maine	829	46.7	972	51.3
Maryland	1,821	41.5	2,037	43.0
Massachusetts	2,585	33.1	2,939	34.2
Michigan	4,343	37.9	4,813	38.3
Minnesota	1,756	31.3	1,809	30.9
Mississippi	2,513	44.1	2,800	46.8
Missouri	2,558	37.6	2,918	40.3
Montana	395	36.1	442	38.7
Nebraska	810	33.0	889	35.5
Nevada	152	50.2	158	52.2
New Hampshire	322	37.7	432	46.1
New Jersey	2,593	34.0	2,796	33.7
New Mexico	1,389	89.1	1,394	91.6
New York	7,535	32.8	8,126	32.7
North Carolina	4,115	45.4	4,416	46.7
North Dakota	479	35.4	468	34.9
Ohio	5,147	38.5	5,640	39.1
Oklahoma	1,923	41.2	2,068	42.5
Oregon	736	30.5	763	30.0
Pennsylvania	7,136	40.0	7,551	37.9
Rhode Island	486	35.3	638	43.5
South Carolina	2,858	54.9	2,985	55.1
South Dakota	445	34.9	457	35.7
Tennessee	3,106	45.5	3,143	44.8
Texas	8,354	50.4	8,454	51.4
Utah	548	33.9	539	31.4
Vermont	277	40.6	285	39.0
Virginia	3,261	47.1	3,395	47.1
Washington	1,506	33.8	1,550	34.8
West Virginia	2,149	52.0	2,261	52.1
Wisconsin	1,972	32.0	2,257	35.0
Wyoming	232	41.2	216	37.1

[1] Tabulations are by place of residence.

[2] Deaths under 1 year, exclusive of stillbirths.

FOR HEALTHIER SCHOOL CHILDREN

By LEONA BAUMGARTNER, M. D., Director, Bureau of Child Hygiene, New York City Health Department, MYRON E. WEGMAN, M. D., Department of Pediatrics, School of Medicine, Louisiana State University, New Orleans, and GEORGE WHEATLEY, M. D., Vice President, Health and Welfare, Metropolitan Life Insurance Company, New York. Given November 14, 1946, at the annual meeting of the American Public Health Association, at Cleveland.

TO WHAT EXTENT have the services designed to improve the health of school children in this country done so? Certainly there have been striking decreases in the morbidity and mortality of the diseases that commonly attack children. Smallpox, measles, diphtheria, impetigo, scabies, pediculosis—these no longer constitute major problems. There is, however, a serious question as to whether the activities carried on in the school are largely responsible for these advances. One cannot gainsay the many reports that have indicated success in correcting physical defects. A number of children have been helped to a better physical condition. And although some of this individual improvement might have come about anyway, through the influence of parents for example, it seems clear that the school often played a significant role. On the other hand, there is little evidence that a generation more aware of its health needs has developed, or that the health instruction that school children are given leads to desirable health practices in adulthood.

Despite these advances, the health status of our school children still leaves much to be desired. The examinations of draftees in World War II have often been misinterpreted. However, these results show that although many defects had been corrected, there were many correctible physical defects known to school authorities which had gone uncorrected. Current activity in both local and national legislative bodies, however, shows that just as in the last postwar period our citizens are concerned with problems of the health of children. They are demanding that the failures of the past shall not recur. They are planning to supply funds for expanded services. How shall we, as experts, advise them?

We shall here discuss only one aspect of the problem, that usually known as the health-service program, or, as we prefer to put it, the activities of doctors, dentists, and nurses which are concerned with the school population. This does not mean we do not have an essential interest in all other phases of the program. All workers in this vineyard have overlapping interests, and mutual planning is essential. From our experience, however, it would be less than realistic to fail to point out that all too often doctors are told what they *should* do by people who do not know what a doctor *can* do. We are therefore confining ourselves to a discussion of direct health services to children.

We believe medical and dental services for school children are still very far from achieving their goals for at least five specific reasons.

1. Our programs have failed to state that their objective is to secure the best services modern medicine has to offer for all children of school age.

2. The public, including parents, taxpayers, and public officials, has not yet become sufficiently aware of the need for giving adequate financial support to develop a satisfactory program.

3. Although there have been important developments in basic medical research, the methods of applying the results of such research to school populations lag far behind in their development.

4. Despite a marked improvement in cooperation among the many groups concerned, we still lack a unified philosophy and set of objectives. Too often well-meaning educators, health officers, physicians, dentists, nurses, and parents spend too much time either talking endlessly on how to cooperate, correlate, integrate, or whatever the acceptable verb may momentarily be. Sometimes departments of education and health actually compete with each other for authority and credit. And in the meantime, graduating class after graduating class leaves the school in poor physical condition because of inadequate medical and dental attention.

5. There are too few persons sufficiently well trained to give adequate service to children. This would seem to be, as the Advisory Committees of the Children's Bureau recently pointed out, the most pressing problem of the immediate future.

We can and must take a new view. To secure more funds, more doctors, more dentists and more nurses just to do the same old job is not enough. It is clear that funds must be allotted, even at the expense of delaying service to some children now in school, to train personnel and to establish continuing research projects, both for fundamental medical research and for developing methods of applying research results to school children. We believe the public will make up its mind to support more adequate programs when it sees more clearly what we are driving at and is sure that we can get results. All this points not only to the need for education and propaganda, but also to the need for a more concrete program. We have, therefore, endeavored to state in more exact terms *what* we believe a good medical and dental service to school children must be. We have divided the discussion into two parts: (A) Establishment of an adequate case-finding program; and (B) maintenance of an adequate follow-up program — that is, doing something about what we discover through the case-finding program.

Adequate case finding comes first

We have used the term case-finding, which is commonly used in connection with controlling specific diseases in the general population, because it emphasizes methods of finding the child who is in need of medical care. An adequate case-finding program for school children demands chiefly: (1) Periodic medical and dental examinations, (2) mass testing procedures, and (3) continuous observations by teachers. There are also other requirements in connection with the examination. One is accessory consultation service by specialists — pediatricians, ophthalmologists, otologists, orthopedists, psychiatrists, psychologists, orthodontics, and so forth. Another is access to diagnostic laboratory service, such as roentgenography, electrocardiography, and serological or hemotological studies. And still another is determination of each child's immunization status, with regard to diphtheria, smallpox, and whooping cough, as well as tetanus and typhoid when indicated.

Periodic examinations

Let us first discuss periodic medical and dental examinations given by persons trained to know medical and dental problems in children.

Medical examinations.—It is clear that thorough examinations by a physician at regular intervals are essential if the health status of the child is to be improved. But how often should these examinations be given? There is pressure from many school authorities for annual examinations. But if these are not thorough and are not accompanied by adequate follow-up programs, they lead to little except a sense of false security for the school and the public. Actually the usual annual-examination program should be exposed as a hoax. Expenditure of public funds for examinations of school children by a physician is justified only if the examintions benefit the child.

The main argument for these examinations is that they discover physical ailments, although this cannot usually be done by means of a hasty examination. Two other arguments are usually advanced: (1) That the examinations protect the school personnel by putting on file a doctor's statement concerning a child's fitness for physical activities; (2) that it inculcates in the child the habit of having an annual physical examination, which he will continue throughout life.

But it is uncertain how much protection the doctor's certificate actually is in case of a lawsuit. And a great many reports of annual examinations are of no value in court, since they do not represent current conditions. Also, it can be easily proved that the examination was so superficially made that the report is of less value than the paper on which it is written.

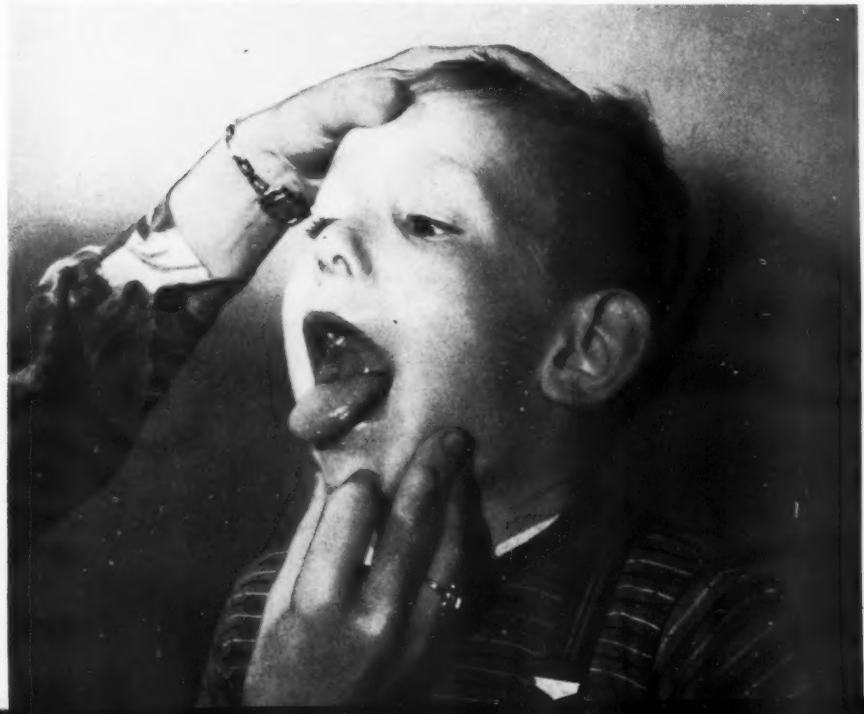
As to forming a habit of having annual examinations, we have no evidence that pupils form such a habit. And certainly it is not good practice to teach that superficial examinations, with the child's clothes on or only partially removed—examinations made at the rate of one a minute—are the medical examinations one should expect from a physician.

Medical examination of a school child is of value when it discovers any ailment the child has, when it leads to the treatment of such ailment, and when it guides the parent in the further care of the child, so that he may achieve his optimal growth and development. Few school systems can now afford both the routine annual examination and the follow-up program. It is generally agreed that the *optimal* management of the school child and adolescent involves a thorough examination annually. But if we cannot now reach this goal, let us examine carefully to see whether we are using what medical service we have as effectively as we can. Let us press toward a goal of four examinations in the course of the child's elementary- and secondary-school career, the goal agreed on by the National Conference for Cooperation in Health Education. It has been clearly demonstrated that when this goal cannot be reached (as is usual), it is more productive to examine the children that have been selected through the daily observation of the teacher than to examine whole classes of children.

Dental examinations.—The problem of giving dental service to children in a public program is always made more difficult by the huge load of work that needs to be done, and, as a rule, with pitifully inadequate facilities. We know that good dental health requires annual—and, much better, semiannual—detailed, careful examination by a dentist, and correction of any lesions found. Inspections by physicians or teachers are no substitute for this. Unquestionably every school should teach children that they need semiannual dental examination and correction, and should support its teaching by making arrangements with dentists and referring children to them.

As to treatment services within the school system, just how to use whatever such services are available has not been answered definitely. Complete cover-

Daily observation by a teacher trained in dealing with health problems helps to find the child who needs medical care.



age of the lower grades has its advocates against those who propose a selective policy of following a limited group throughout its school career. Here, again, the need for public-health research in dentistry is vital. It seems clear, however, that since dental caries is prevalent throughout the United States the time of school dentists should be spent in filling cavities and in protecting the teeth and oral tissues, instead of merely searching for caries, which is obviously present most of the time.

Mass testing

The second essential for an adequate case-finding program is a procedure for detecting special conditions, such as tuberculosis, parasitic infections, and nutritional status. For this purpose it will be necessary to have available facilities for mass testing of the school children.

Observation by teachers

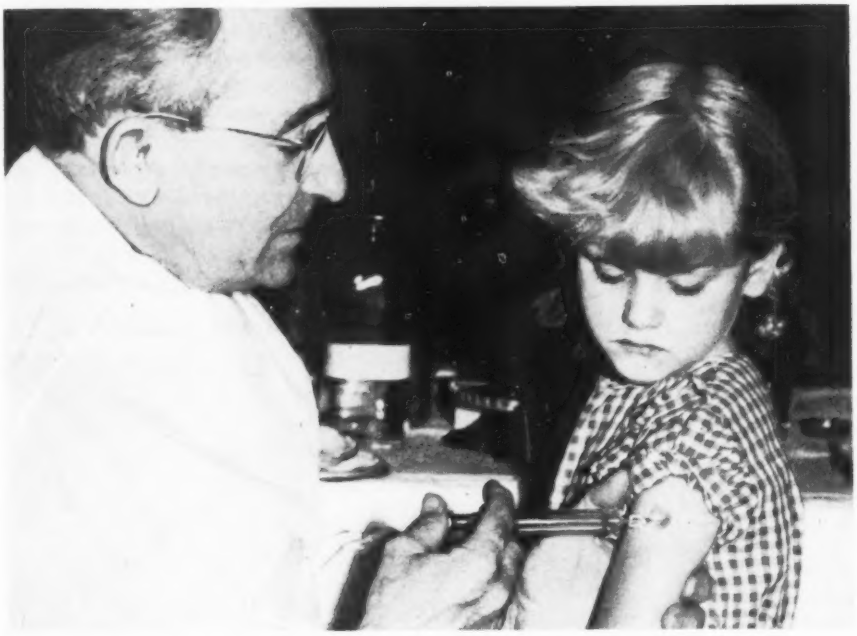
We have listed continuous observation by teachers as the third chief need for case finding. In recent years we have found great emphasis laid on this activity. But when teachers are insufficiently trained in dealing with health problems it may be only a formality. The current revisions of syllabi on health that are used in teacher-training institutions have recognized this fact, but even now the training in this field is hardly adequate. Much more attention must be given to organized, effective training of teachers in observation of pupils' health.

Follow-up programs must be strengthened

We have long known that case finding without adequate follow-up is extravagant and almost useless. The lack of good follow-up has been the greatest weakness of health service for school children in America. In many schools the objective of the health program—if it has an objective—would seem to be completion of statistics on the number of defects found, or attainment of 100-percent examination of children annually or biennially. If such things are the objectives, little wonder so many children leave school with unimproved health. Let us see what is needed if we are to concentrate on getting something done about what is found.

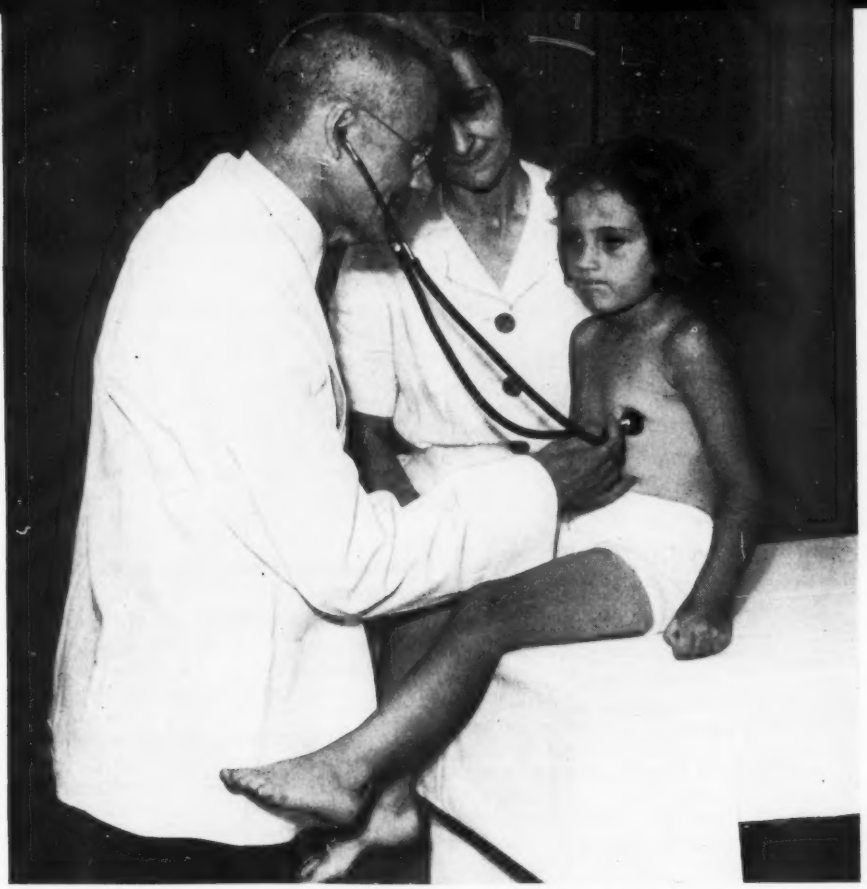
First, there must be an effective interpretation of the findings and recommendations to parents, children, teachers, administrators, and others concerned with the health and welfare of the child. Due regard should be given to safeguarding so-called confidential information, but such safeguards should not militate against the child's obtaining what he needs. Interpretations of this kind are, for the most part, inadequately done. Too little time is allotted and personnel are often too poorly trained to give or receive such information successfully. Doctors are usually engaged to "make examinations" and are often given little or no time to tell parents or teachers what needs to be done. Still, physicians and teachers have much to learn in this area. Nurses and social workers are usually better prepared to carry out this part of the program.

Many ills can be prevented, and the cost of preventing them is usually less than the cost of care after the damage is done.



Secondly, school children must have access to continuing professional services so that their medical and dental needs may be cared for. Although many communities have serious lacks, in general the United States has the richest medical resources in the world. But until such time as we find a way to lead our school children to proper resources for medical and dental care and psychological guidance, we shall not have an effective health service for school children. This does not mean we are advocating that schools should establish complete treatment facilities. Far from it. They have their own educational functions to perform. Treatment facilities are needed by all in the community. School and health authorities must, however, find ways of making the facilities that exist in the community readily accessible to school children and find ways of stimulating the community to furnish enough so that all may be cared for. The care given in the offices of private physicians and dentists, and paid for by parents, must be included when over-all facilities are surveyed. Let us face honestly the fact that we have for years discovered thousands of school children who need further medical care and whose parents will not or cannot supply it. And we have failed to plan how *all* children will get the care they need.

These curative services must include laboratory diagnostic services, facilities for immunization against the preventable communicable diseases, and facilities for the correction of abnormalities of vision and hearing and for the treatment of parasitic infections; tuberculosis, psychiatric problems, and other



Instead of an annual routine examination, let us press toward a goal of four thorough ones during the child's elementary- and secondary-school career, the goal that has been agreed on by the National Conference for Cooperation in Health Education.

conditions that are discovered through case-finding procedures.

Thirdly, actual follow-up work with school childen is best guided by a public-health nurse. Her day-to-day work in schools and homes brings results. Every school child needs her services. But careful planning is needed to avoid duplication in the community's nursing services. The principle of generalized nursing service has been established to avoid just this duplication. Certainly where more than one nurse visits a home it is essential that each nurse knows what the other is doing.

At this point, a word should be said about the need for guidance of the nurse so that she will know which recommendations are urgent and which are not. For a concrete example: The great vogue for tonsillectomy, fortunately weakening but still very much alive, has wasted countless hours for nurses who have energetically tried to persuade mothers that a tonsillectomy and adenoidectomy was necessary, when the indications were of the scantiest. Tonsillectomy is such a nice specific thing to do, of course, and so much of the advice given in other conditions is rather intangible, that both school physicians and nurses seized on the procedure with delight. Right now, a great part of the nurses' follow-up work has to do with taking out tonsils. Let the school physicians be honest and realistic. Let them indicate definitely for the nurses' guidance which of the cases—very few to be sure—really require "T & A." Then the nurse can clear her follow-up file and turn her attention to more important things.

And let us not forget that the child who is sick at home or in the hospital must also have good nursing care.

Finally, the child who needs care in a convalescent home or a residential school, or psychiatric care, or social services should be given access to these.

The program for school children just outlined may sound fantastic, particularly for the rural school or the school system that employs a doctor one week out of the year for a preschool roundup. But service of this kind is essential if school children are to benefit from what American medicine has to offer them. Perhaps if we were to concentrate on this type of program as our objective we would no longer find taxpayers, parents, school superintendents, and doctors content to have examinations done at the rate of 15 an hour. We might even find the taxpayer interested in supporting something he could be more sure would bring results than today's program.

Certainly many of the ills of adulthood have their beginning in childhood, and certainly many of them can be prevented. And the cost of prevention is usually less than the cost of care after the damage is done.

But there is no assurance today that the school child who needs medical care will get it.

Many programs for reorganization of medical care in general are in progress today, and the time for reorganization of health services in schools is also here. Ways of pulling the two programs together must be found. That peculiar gift for organization, of which we Americans boast as our greatest asset, *can* solve this problem. But we must emerge from our current lethargy, must leave our individual and group selfishnesses behind, and must actually plan and execute a program of health for school children that brings to them the best we have to offer.

The careful reader may have noticed that nowhere in this discussion have the words "school health" appeared. We have deliberately avoided these words, hoping that emphasis on health for school children will point out that the time for change is here. And we believe that until all the skills now known to pediatrics, dentistry, psychiatry, psychology, nursing, sociology, and education are used, we shall not achieve our ends. Our so-called "school health" programs need to be scrutinized with a critical eye, and they must be measured against what American medicine can do. What phases of our program are effective and which are merely carrying out old routines? And though cooperation of workers in all these fields is essential, the medical and dental problems of school children will not be solved until competent medical and dental leadership brings about real programs, which assure every child effective medical supervision and care.

Reprinted from the Yale Journal of Biology and Medicine, March 1947.

MORTALITY RATES

(*Continued from page 153*)

every 1,000 live births, stillbirths numbered 26.7 in 1943, and 27.0 in 1944. Almost twice as many stillbirths per 1,000 live births occurred in the nonwhite as in the white population. Total loss of life, through stillbirths and neonatal deaths, came to 51.7 per 1,000 live births in 1944. Better care during pregnancy is essential if this rate is to be reduced.

Attendance at birth—Over the years improvement has definitely been taking place in the proportion of mothers and infants attended professionally at birth. Both in 1944 and 1943, 93 out of every 100 births were attended by a physician, either in a hospital or at home. 1944 showed an increase in the proportion of births taking place in hospitals (75.6 percent, as compared with 72.1 in 1943) and a corresponding decrease in deliveries at home under medical care.

Differences in attendance at birth between white and nonwhite and between urban and rural births help to highlight the areas where progress still needs to be made.

Against the 98 percent of white births—in both 1944 and 1943—which were attended by physicians stand the relatively low percentages for nonwhite births: 60 percent in 1944 and 57 percent in 1943. As late as 1944, that is, 4 out of every 10 nonwhite births occurred without any medical attention. The District of Columbia, which has a sizable Negro population, made an outstanding record in 1944, with practically 100 percent of both white and nonwhite births under a doctor's care. Of course, the District of Columbia is an urban area, and therefore its rate is not comparable with a State that averages rural and urban conditions.

All but 2 percent of the urban births in both 1944 and 1943 were attended by a physician, either in a hospital or in the home. Thirteen percent of the rural births in the same years received no medical care. An even greater difference exists in the proportion taking place in hospitals; for urban births, the percentages were 89 in 1944 and 87 in 1943; for rural, 57 in 1944, and 51 in 1943.

IN THE NEWS

Recent developments in some American Republics

CHILE

Supervision of Child-Welfare Services Outside the Capital

Supervision over child-welfare services in Chile, outside the capital, was delegated late in 1945 to the National Bureau for the Welfare of Children and Youth, which has had charge of this work in the capital since 1942.

SOURCE: Diario Oficial de la República de Chile, December 26, 1945.

COLOMBIA

Improvement of Conditions in Institutions

According to regulations issued by the Minister of Labor, Health, and Social Welfare on August 21, 1946, every child-welfare institution must provide for the children medical and dental care, a general elementary education, and training in a trade or farming. Through social workers the institution is required to maintain relations with the child's family. Records must be kept and reports presented to the authorities supervising the institution.

Standards for foster-home placement and the duties of social workers in this work are also prescribed in the regulations.

SOURCE: Revista Colombiana de Pediatria y Puericultura, June 1946.

THE DOMINICAN REPUBLIC

Social Insurance

The enactment of a social-insurance law in the Dominican Republic was proposed by the President of that country in December 1946.

SOURCE: Information Bulletin issued by the Dominican Embassy, December 23, 1946.

GUATEMALA

Social Insurance

Social insurance for all employed persons in Guatemala was the subject of a law of October 30, 1946. In case of illness insured persons will receive cash payments and medical and surgical care. The same care will be available for the dependent wife and children of the insured person.

The maternity benefits for an insured woman consist of a cash payment for a specified period of time and medical and surgical care in pregnancy, childbirth, and the postnatal period. Additional payments will be made to those who nurse their children. The law also provides benefits for widows and orphans of insured persons.

Measures are ordered for the enforcement of the law.

SOURCE: Diario de Centro-America, October 31, November 1, 4, and 11, 1946.

School Census

In compliance with an order of the President of the Republic, a census of school children was taken in Guatemala early in 1946. The purpose of the census was to ascertain the number of children of school age and of those who failed to attend school as required by law; also the reasons for their failure to do so.

PANAMA

Organization of National Council on Children and Youth

The organization of the National Council on Children and Youth (Consejo Nacional para Menores) in Panama was ordered by a law of September 27, 1946.

The council is to include the director of the Institute of The Child, the president of the National Board of Nutrition, and representatives of the National Red Cross, the Social Insurance Fund, and several Government departments.

The council is to meet at least twice a month. The members will serve without compensation.

The law has assigned to the council the following functions:

(1) Study of problems relating to children and youth;

(2) Promotion of the establishment of juvenile courts, vacation camps, school-lunch programs, and other services for children;

(3) Answering inquiries from Government agencies and private organizations and individuals and making recommendations to them;

(4) Cooperation with the Ministry of Labor, Social Welfare, and Public Health in matters relating to child welfare;

(5) Drafting a children's code;

(6) Organization of an annual child-welfare congress.

The council is authorized to establish in each province a child-welfare board, which is expected to cooperate with other agencies engaged in child-welfare work.

The council may use the services of persons trained in child welfare, whether they are residents of Panama or not.

The law establishing the council carries with it an appropriation for the work.

SOURCE: Gaceta Oficial, Panama, September 30, 1946.

New Constitution Adopted, 1946

The new Constitution, adopted in Panama in 1946, proclaims the duty of the State to protect the family and the child. To this end it orders the enactment of various child-welfare measures; it prohibits child labor in accordance with the internationally accepted standards, and it makes school attendance compulsory and primary and secondary education free.

In the matter of public health the constitution places on the State the functions of safeguarding motherhood, reducing infant mortality, instituting medical supervision over school children's health, and providing adequate food for mothers and children. It also orders the establishment in each locality of sufficient hospitals, general clinics, and dental clinics, with free services to persons of low income.

Anna Kalet Smith.

Texas organizes committee for children and youth

The Texas Committee for Children and Youth was organized in November 1946, with Mrs. George H. Abbott of Dallas as chairman. The purpose of the committee is "to assemble and distribute facts pertaining to the needs and care of children and youth in Texas, and to coordinate the efforts in behalf of their health, education, and social welfare." Membership is open to "any agency, organization, or person interested in the objectives of the organization."

Planning for a committee started last spring in a meeting of representatives of some 50 State-wide organizations and agencies, called by the Texas Social Welfare Association. The bylaws of several State committees were studied, and those of the Kansas Council for Children chosen as the type which seemed to be most suitable for the purposes of the proposed committee.

The participating groups were definite in their thinking that the Texas Committee for Children and Youth should be organized primarily to study, plan, and coordinate.

Stella Scurlock.

Correction: The price of "Bibliography of Books for Children" published by the Association for Childhood Education is 75 cents. Through a typographical error it was incorrectly reported in the January *Child* as 5 cents.

Children not to blame for most damage in homes, survey shows

Relatively few of the common types of tenant wear and tear on rental properties can be attributed to children, the Federal Housing Agency reports.

A survey of the most common types of misuse and breakage occurring in public low-rent housing in the United States showed that housewives often caused more damage than children, frequently by ill-advised cleaning methods.

The findings are particularly significant in view of the Government's recent plea to landlords not to ban families with children from their properties. Some landlords refuse to rent to such families because they believe children cause extra maintenance and repair costs.

SOURCE: FPHA Bulletin, December 1, 1946. Federal Public Housing Authority, National Housing Agency.

American Legion adopts resolutions on child welfare

Since approximately half the youth of America are the children of veterans, the American Legion feels that if the living conditions of veterans' children are to be improved, the Legion must work for the betterment of the living conditions of all children.

At its 1946 annual convention, held in San Francisco October 3, the Legion reaffirmed the goal of its established child-welfare program, "A Square Deal for Every Child," and voted to extend the program more widely. The American Legion's child-welfare program, first adopted at its 1924 convention, is described as a program to serve the whole child in his physical, mental, emotional, and spiritual well-being.

According to the resolutions adopted at the convention the Legion plans a number of steps, among which are the following:

(1) To work for State and national increases in appropriations under the Social Security Act for aid to dependent children.

(2) To recommend that public-assistance funds be based upon the needs of the child rather than set as a fixed sum; and that the practice of prescribing a maximum allowance for aid to dependent children be abolished wherever such exists.

(3) To appoint an advisory committee consisting of representatives of various faiths to assist in the preparation of booklets on religious instruction.

(4) To recommend that eligibility for crippled children's care and treatment under the Social Security Act be determined by a medical decision, thus eliminating the necessity for court action.

(5) To reaffirm the "Children's Charter" of the 1930 White House Conference and strive to accomplish its objectives.

(6) To cooperate in efforts on juvenile delinquency and in aiding youth to make America a better place in which to live.

(7) To work to eliminate publication and distribution of salacious and obscene literature.

(8) To work to substitute wholesome radio programs for those dealing with crime and easy money.

(9) To work in the States for adequate standards and equipment for prevention and treatment of juvenile delinquency.

Stella Scurlock

CONFERENCE CALENDAR

Mar. 12—Girl Scout 35th Anniversary Day. Girl Scouts, 155 East 44th Street, New York. Slogan: "Better Citizens Build a Better World."

Mar. 13–15—American Camping Association. New York.

Mar. 28–29—Play Schools Association. Annual conference. New York.

Mar. 30–Apr. 6—National Negro Health Week.

Apr. 13–19—National Conference of Social Work. San Francisco.

Apr. 20–26—Public Health Nursing Week. Further information from the National Organization for Public Health Nursing, Inc. 1790 Broadway, New York 19.

Apr. 21–26—American Association for Health, Physical Education, and Recreation. Annual convention. Seattle, Wash.

May 2–3—American Council on Education. Thirtieth annual meeting. Washington.

School children like the boy on our March cover should not lack effective health services in the country with the richest medical resources in the world. Library of Congress photograph by John Vachon, for Farm Security Administration.

Other credits:

Page 146, photograph by Berkshire Evening Eagle, Pittsfield, Mass.

Page 147, photograph by Larry Schreiber for St. Paul Community Chest.

Page 149, photograph by Peter Sekaer for Federal Public Housing Authority.

Page 155, Library of Congress photograph by Marjory Collins.

Page 156, Children's Bureau photograph.

Page 157, photograph by E. A. Powell for South Carolina State Board of Health.

ELLEN WILKINSON NEVER GAVE UP

When death claimed Ellen Wilkinson, Minister of Education in the British Labor Government, on February 6, not only Britain's children but children everywhere lost one of their greatest friends and most spirited protectors. The legacy she leaves them is the vivid memory of herself as a person and the example of the fearlessness and devotion of her career as citizen and as Minister.

What she wanted was a fair start for all children, and public responsibility and participation in the upbringing of generations of healthy and educated citizens. The "sins" of the fathers and mothers—their poverty, ignorance, and ill-health—she felt should not be visited on the children.

Once, listening to her speak in the House of Commons, an old gentleman sitting beside me in the visitors' gallery leaned over and whispered: "Remember Chesterton's poem, 'For these are the people of England and they have not spoken yet?' They're speaking now. She's speaking up!"

Millions, both in her own party and outside it, felt for her the affectionate respect the GIs had for the jeep. She never gave up when the going was rough.

Her childhood was spent in a slum in Manchester. She was the daughter of a cotton-mill worker who never earned more than $16 a week in his life. Scholarships got her her education from the time she was 11. She got her M. A. degree in history from Manchester University.

When she was 31 she was elected to Parliament by the Middlesbrough East Division as Labor Member, a seat she held from 1924 to 1931. In 1935 she was again elected to Parliament, from the Jarrow Division of Durham, and this seat she held until her death. She was always among the first to protest against injustice. She was impulsive and eloquent, and within her party organization and outside she became a proponent of the individual's right to speak.

During the recent war she served as parliamentary secretary to the Ministry of Pensions and later as parliamentary secretary to the Ministry of Home Security. In 1945 she became the second woman in history to hold office as a British Cabinet Minister.

As Minister of Education, she was charged with providing schoolhouses and teachers for a greater proportion of English children than ever before. Better education and more of it was her slogan, as the way to rebuild victorious but blitzed England. Hers was the job of administering the program under the law raising the school age from 14 to 15. Hers was the job of administering a commitment of spending $95,000,000 for new school buildings. England can ill spare her competence, imagination, and courage.

But the work she did in helping to prepare the plans for UNESCO—the United Nations Educational, Scientific and Cultural Organization—remains as well as her persuasive faith that care for children's health and education is the broad base of any nation's future.

What fathers and mothers covet for their own children, they should covet and create for all. Ellen was that way. If by her witty journalism, she earned an iceless refrigerator, or a little car, she immediately wanted others to share them and to possess duplicates.

She wanted to educate the people to create, to find power for making things, rather than for destroying them in an atomic age.

She practiced patience and impatience, found fun in hard work and more fun in harder work, understood the technical machinery of modern industry and civil administration, and yet maintained a private life of devotion to an invalid sister, and delight to many friends. She firmly believed that you had to work harder in peace than in war, lest further wars betide.

Everyone Evans

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SOCIAL SECURITY ADMINISTRATION

CHILDREN'S BUREAU
Katharine F. Lenroot, Chief

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